FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040295

Facility Name: RENAISSANCE CARE CENTER

Address: 1675 E. ASH STREET (Number) CANTON (City) 61520 (Zip Code)

County: FULTON

Telephone Number: (847)674-4700 **Fax #** (847)674-4733

IDPA ID Number: 36-1304212

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847)675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	152	Skilled (SNF)	152	55,480	1
2	42	Skilled Pediatric (SNF/PED)	42	15,330	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	194	TOTALS	194	70,810	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,862	1,862	8
9	SNF/PED	14,721			14,721	9
10	ICF	19,765	2,038	98	21,901	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,486	2,038	1,960	38,484	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.35%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,862

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	126,750	4,560	6,050	137,360		137,360		137,360			1
2	Food Purchase		262,930		262,930		262,930	(8,464)	254,466			2
3	Housekeeping	127,525	40,135		167,660		167,660	413	168,073			3
4	Laundry	52,096	20,926	566	73,588		73,588		73,588			4
5	Heat and Other Utilities			104,450	104,450		104,450	666	105,116			5
6	Maintenance	41,486	22,029	19,926	83,441		83,441	684	84,125			6
7	Other (specify):* SCAVENGER			7,187	7,187		7,187		7,187			7
8	**TOTAL General Services**	347,857	350,580	138,179	836,616		836,616	(6,701)	829,915			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,746,446	196,297	84,201	2,026,944		2,026,944	17,700	2,044,644			10
10a	Therapy		1,071	1,604	2,675		2,675		2,675			10a
11	Activities	38,802		2,118	40,920		40,920		40,920			11
12	Social Services	30,760		5,490	36,250		36,250		36,250			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,816,008	197,368	93,413	2,106,789		2,106,789	17,700	2,124,489			16
	C. General Administration											
17	Administrative	24,100		17,000	41,100		41,100	29,263	70,363			17
18	Directors Fees											18
19	Professional Services			63,812	63,812		63,812	9,694	73,506			19
20	Dues, Fees, Subscriptions & Promotions			44,400	44,400		44,400	(12,008)	32,392			20
21	Clerical & General Office Expenses	74,656	15,113	162,955	252,724		252,724	(40,353)	212,371			21
22	Employee Benefits & Payroll Taxes			331,683	331,683		331,683	19,511	351,194			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,392	1,392		1,392	8,142	9,534			24
25	Other Admin. Staff Transportation			11,467	11,467		11,467	8,350	19,817			25
26	Insurance-Prop.Liab.Malpractice			90,394	90,394		90,394	4,616	95,010			26
27	Other (specify):*											27
28	**TOTAL General Administration**	98,756	15,113	723,103	836,972		836,972	27,215	864,187			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,262,621	563,061	954,695	3,780,377		3,780,377	38,214	3,818,591			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number RENAISSANCE CARE CENTER #0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,104	30,104		30,104	229,204	259,308			30
31	Amortization of Pre-Op. & Org.							4,260	4,260			31
32	Interest			23,089	23,089		23,089	621,898	644,987			32
33	Real Estate Taxes			40,486	40,486		40,486		40,486			33
34	Rent-Facility & Grounds			760,239	760,239		760,239	(754,554)	5,685			34
35	Rent-Equipment & Vehicles			14,954	14,954		14,954		14,954			35
36	Other (specify):*											36
37	**TOTAL Ownership**			868,872	868,872		868,872	100,808	969,680			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			97,444	97,444		97,444		97,444			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			106,215	106,215		106,215		106,215			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			203,659	203,659		203,659		203,659			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,262,621	563,061	2,027,226	4,852,908		4,852,908	139,022	4,991,930			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(37,471)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(8,251)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(213)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,868)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,433)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	1,993	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,243)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	202,265		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 202,265		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 139,022		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

RENAISSANCE CARE CENTER

ID# 0040295

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINT	$ 1,993	30	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	1,993		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE CARE CENTER **#** 0040295 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,464)	0	0	0	0	0	0	0	0	0	0	(8,464)	2
3	Housekeeping	0	0	413	0	0	0	0	0	0	0	0	413	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	666	0	0	0	0	0	0	0	0	666	5
6	Maintenance	0	0	684	0	0	0	0	0	0	0	0	684	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,464)	0	1,763	0	0	0	0	0	0	0	0	(6,701)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	17,700	0	0	0	0	0	0	0	0	17,700	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	17,700	0	0	0	0	0	0	0	0	17,700	16
	C. General Administration													
17	Administrative	0	(17,000)	46,263	0	0	0	0	0	0	0	0	29,263	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	9,694	0	0	0	0	0	0	0	0	9,694	19
20	Fees, Subscriptions & Promotions	(12,433)	0	425	0	0	0	0	0	0	0	0	(12,008)	20
21	Clerical & General Office Expenses	(6,868)	(132,798)	99,313	0	0	0	0	0	0	0	0	(40,353)	21
22	Employee Benefits & Payroll Taxes	0	0	19,511	0	0	0	0	0	0	0	0	19,511	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,142	0	0	0	0	0	0	0	0	8,142	24
25	Other Admin. Staff Transportation	0	0	8,350	0	0	0	0	0	0	0	0	8,350	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,616	0	0	0	0	0	0	0	0	4,616	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(19,301)	(149,798)	196,314	0	0	0	0	0	0	0	0	27,215	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,765)	(149,798)	215,777	0	0	0	0	0	0	0	0	38,214	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(35,478)	261,720	2,962	0	0	0	0	0	0	0	0	229,204	30
31	Amortization of Pre-Op. & Org.	0	4,260	0	0	0	0	0	0	0	0	0	4,260	31
32	Interest	0	621,822	76	0	0	0	0	0	0	0	0	621,898	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(760,239)	5,685	0	0	0	0	0	0	0	0	(754,554)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(35,478)	127,563	8,723	0	0	0	0	0	0	0	0	100,808	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(63,243)	(22,235)	224,500	0	0	0	0	0	0	0	0	139,022	45

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTI	SKOKIE	BOOKKEEPING/
				MANAGEMENT		MANAGEMENT
				CHM THERAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 17,000			$	$ (17,000)	1
2	V	21	BOOKKEEPING SVC	132,960				(132,960)	2
3	V								3
4	V								4
5	V								5
6	V	34	RENT	760,239	RENAISSANCE CARE CENTER LLC			(760,239)	6
7	V								7
8	V	21	OFFICE EXPENSE		" " " "		162	162	8
9	V	30	DEPRECIATION		" " " "		261,720	261,720	9
10	V	31	AMORTIZATION		" " " "		4,260	4,260	10
11	V	32	INTEREST		" " " "		621,822	621,822	11
12	V								12
13	V								13
14	Total			$ 910,199			$ 887,964	$ * (22,235)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$			$ 413	$ 413	15
16	V	5	ELECTRICITY & GAS				666	666	16
17	V	6	MAINTENANCE				684	684	17
18	V	10	NURSING/MEDICAL RECORDS				17,700	17,700	18
19	V	17	ADMIN SALARIES				46,263	46,263	19
20	V	19	PROFESSIONAL FEES				9,694	9,694	20
21	V	20	FEES, SUBSCRIPTIONS				425	425	21
22	V	21	OFFICE EXPENSE				99,313	99,313	22
23	V	22	EMPLOYEE BENEFITS				19,511	19,511	23
24	V	24	TRAVEL/SEMINAR				8,142	8,142	24
25	V	25	TRANSPORTATION				8,350	8,350	25
26	V	26	INSURANCE				4,616	4,616	26
27	V	30	DEPRECIATION				2,962	2,962	27
28	V	32	INTEREST				76	76	28
29	V	34	OFFICE RENT				5,685	5,685	29
30	V	35	EQUIPMENT RENT				0		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 224,500	$ * 224,500	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED				$ 12,275	17-7	1
2	HOWARD GELLER		ADMINISTRATIVE						4,725	19-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 17,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	279,537	8	$ 3,000	$	38,484	$ 413	1
2	5	ELECTRICITY & GAS	" " "	279,537	8	4,839		38,484	666	2
3	6	MAINTENANCE	" " "	279,537	8	4,965		38,484	684	3
4	10	NURSING/MEDICAL RECORDS	" " "	279,537	8	128,566	128,566	38,484	17,700	4
5	17	ADMIN SALARIES	" " "	279,537	8	336,038	336,038	38,484	46,263	5
6	19	PROFESSIONAL FEES	" " "	279,537	8	70,412		38,484	9,694	6
7	20	FEES, SUBSCRIPTIONS	" " "	279,537	8	3,089		38,484	425	7
8	21	OFFICE EXPENSE	" " "	279,537	8	721,384	572,980	38,484	99,313	8
9	22	EMPLOYEE BENEFITS	" " "	279,537	8	141,722		38,484	19,511	9
10	24	TRAVEL/SEMINAR	" " "	279,537	8	59,144		38,484	8,142	10
11	25	TRANSPORTATION	" " "	279,537	8	60,651		38,484	8,350	11
12	26	INSURANCE	" " "	279,537	8	33,528		38,484	4,616	12
13	30	DEPRECIATION	" " "	279,537	8	21,518		38,484	2,962	13
14	32	INTEREST	" " "	279,537	8	549		38,484	76	14
15	34	OFFICE RENT	" " "	279,537	8	41,293		38,484	5,685	15
16	35	EQUIPMENT RENT	" " "	279,537	8				0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,630,698	$ 1,037,584		$ 224,500	25

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BANK FINANCIAL		X	MORTGAGE	$14,812.00	4/00	$ 715,867	$ 553,945	9/02	10.5000	$ 48,054	1
2	GERSHON BASSMAN	X		MORTGAGE	$16,993.00	4/00	1,789,668	1,733,765	3/20	9.7500	170,677	2
3	CIB BANK		X	MORTGAGE	$39,927.00	4/00	4,152,030	4,039,901	3/20	9.7500	403,091	3
4												4
5	SHAREHOLDER/OFFICER	X		WORKING CAPITAL				4,225			393	5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL				463,034			20,633	6
7	AICC		X	INS FINANCING							2,063	7
8	RELATED PARTY	X									76	8
9	TOTAL Facility Related				$71,732.00		$ 6,657,565	$ 6,794,870			$ 644,987	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,657,565	$ 6,794,870			$ 644,987	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	39,207	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	39,452	2
3. Under or (over) accrual (line 2 minus line 1).	$	245	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	40,241	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	40,486	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	40,383	8
	1997	37,551	9
	1998	35,422	10
	1999	38,438	11
	2000	39,452	12

THE CURRENT YEAR R/E TAX ACCRUAL IS BASED ON 103% OF THE PRIOR YEAR BILL

THE PAYMENT ON LIE 2 APPLIES TO THE 2000 TAX YEAR

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RENAISSANCE CARE CENTER COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0040295

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 X40 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-25-101-025		$ 39,451.78	$ 39,451.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,451.78	$ 39,451.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 291,000	1
2					2
3	TOTALS			$ 291,000	3

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	194		2000		$ 5,238,000	$ 190,136	27.5	$ 190,473	$ 337	$ 325,067	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1993	9,646	303	39	303		2,631	9
10	LEASEHOLD IMPROVEMENTS			1994	9,445	242	39	242		1,761	10
11	TILE,OVERBED FIXTURES, AC			1995	2,316	74	39	74		471	11
12	WATER/GAS LINE WORK			1995	6,797	216	39	216		1,393	12
13	ROOF REPAIR			1995	2,060	65	39	65		398	13
14	NURSE STATION			1997	5,222	133	39	133		679	14
15	ROOF REPAIR			1997	7,235	186	39	186		883	15
16	WATER STORAGE TANK			1997	6,550	168	39	168		808	16
17	CARPET, LIGHT FIXTURES			1997	4,570	117	39	117		547	17
18	DOORS			1998	3,264	83	39	83		307	18
19	ROOFING			1998	7,000	179	39	179		589	19
20	WALLPAPER, TILES, BUMPER GUARDS			1998	26,992	694	39	694		2,239	20
21	LANDSCAPING, SIDEWALK,FENCE			1998	10,578	270	39	270		867	21
22	FLOOR/CEILING TILE			1999	8,975	230	39	230		662	22
23	LANDSCAPING			1999	12,187	313	39	313		821	23
24	OUTDOOR SIGN			2000	1,023	37	27.5	37		63	24
25	ROOF REPAIR			2000	8,123	295	27.5	295		368	25
26	ROOFTOP CONDENSER UNITS			2001	4,850	76	27.5	76		76	26
27	LIFT			2001	1,396	6	27.5	6		6	27
28	ROOF IMPROVEMENTS			2001	42,200	320	27.5	320		320	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,418,429	$ 194,143		$ 194,480	$ 337	$ 340,956	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 197,889	$ 21,138	$ 19,789	$ (1,349)	10 YRS	$ 99,782	71
72	Current Year Purchases	4,862	174	243	69	10 YRS	243	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	348,135	71,584	34,814	(36,770)			74
75	TOTALS	$ 550,886	$ 92,896	$ 54,846	$ (38,050)		$ 100,025	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$ 5,840	$ 336	$	$ (336)		$ 6,570	76
77				18,831	1,775	2,353	578		18,831	77
78				13,900	2,673	2,673			7,228	78
79										79
80	TOTALS			$ 38,571	$ 4,784	$ 5,026	$ 242		$ 32,629	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,298,886	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 291,823	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 254,352	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,471)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 473,610	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,954 Description: SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 25,714	$		$ 25,714	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,923			12,923	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			57,658			57,658	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RESPIRATORY					1,149			1,149	13
14	TOTAL			$		$ 97,444	$		$ 97,444	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 22,000)	995,302		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115,657		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	266,889		8
9	Other(specify): RE ESCROW	11,082		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,388,930	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	180,429		15
16	Equipment, at Historical Cost	222,491		16
17	Accumulated Depreciation (book methods)	(189,470)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 213,450	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,602,380	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 506,556	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,500		28
29	Short-Term Notes Payable	490,639		29
30	Accrued Salaries Payable	90,532		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,232		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,241		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,141,700	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,225		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	267,062		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 271,287	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,412,987	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 189,393	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,602,380	$	48

***(See instructions.)**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (75,502)	1
2	Restatements (describe):		2
3	**adjust prior liability to medicare**	179,464	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 103,962	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	85,431	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 85,431	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 189,393	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,760,876	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,760,876	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	120,800	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 120,800	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	8,251	28
28a	PRIOR YEAR ADJUSTMENTS	48,412	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 56,663	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,938,339	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	836,616	31
32	Health Care	2,106,789	32
33	General Administration	836,972	33
	B. Capital Expense		
34	Ownership	868,872	34
	C. Ancillary Expense		
35	Special Cost Centers	97,444	35
36	Provider Participation Fee	106,215	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,852,908	40
41	**Income before Income Taxes (line 30 minus line 40)****	85,431	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 85,431	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	1,960	$ 43,192	$ 22.04	1
2	Assistant Director of Nursing	1,560	1,560	18,972	12.16	2
3	Registered Nurses	5,994	6,608	120,555	18.24	3
4	Licensed Practical Nurses	25,771	26,804	432,874	16.15	4
5	Nurse Aides & Orderlies	99,070	102,010	994,963	9.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,832	1,872	13,192	7.05	8
9	Activity Director	1,040	1,040	10,795	10.38	9
10	Activity Assistants	3,704	3,912	28,007	7.16	10
11	Social Service Workers	2,990	3,178	30,760	9.68	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	19,540	9.39	13
14	Head Cook	4,866	5,260	32,645	6.21	14
15	Cook Helpers/Assistants	10,810	11,284	74,565	6.61	15
16	Dishwashers					16
17	Maintenance Workers	2,177	2,345	41,486	17.69	17
18	Housekeepers	19,268	20,141	127,524	6.33	18
19	Laundry	9,003	9,041	52,096	5.76	19
20	Administrator	1,186	1,226	24,100	19.66	20
21	Assistant Administrator					21
22	Other Administrative	1,976	2,080	31,538	15.16	22
23	Office Manager	2,009	2,145	22,329	10.41	23
24	Clerical	2,001	2,145	20,790	9.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,382	3,606	42,358	11.75	28
29	Resident Services Coordinator	1,976	2,080	36,459	17.53	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,000	2,080	14,834	7.13	31
32	Other Health C: care plan coord	1,960	2,080	29,047	13.96	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,471	216,537	$ 2,262,621 *	$ 10.45	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,050	L1C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,621	L10C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		1,149	L10C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,490	L10C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,310		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	528	$ 14,786	L10C3	50
51	Licensed Practical Nurses	1,726	45,463	L10C3	51
52	Nurse Aides	321	7,338	L10C3	52
53	TOTAL (lines 50 - 52)	2,575	$ 67,587		53

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TINA BATTERTON	ADMINISTRATOR	0	$ 6,689
STELLA DURDLE	ADMINISTRATOR	0	6,217
EILEEN KARTER	ADMINISTRATOR	0	10,298
LISA MEADS	ADMINISTRATOR	0	896
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 24,100

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 17,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 17,000

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick, Bokor	Acctg	$ 10,450
Richard Peelo & Assoc.	Acctg	3,750
Winston & Strawn	Legal	7,018
Rosenthal & Schanfield	Legal	589
Michael Best & Assoc	Legal	1,402
Tenney & Bentley	Legal	2,138
Certified Health	Admin Consult	27,563
Easter Seals	Psych Evals	876
Econocare	Operations Consult	2,713
Personnel Planners	HR Consult	1,635
Related Party		9,694
Millenium/Paymaster	Data Processing	5,678
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 73,506

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,286
Unemployment Compensation Insurance	27,151
FICA Taxes	173,091
Employee Health Insurance	72,261
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other	894
Related Party	19,511
TOTAL (agree to Schedule V, line 22, col.8)	$ 351,194

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,047
Health Care Worker Background Check (Indicate # of checks performed)	
ADVERTISING	12,433
LICENSE/PERMITS	2,040
DUES & SUBSCRIPTIONS	11,880
RELATED PARTY	425
Less: Public Relations Expense	( )
Non-allowable advertising	(12,433)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,392

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party	8,142
Seminar Expense	
SEMINARS	1,392
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,534

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1996	$	5	$ 2,639	$ 2,639	$ 2,639	$ 1,319	$	$	$	$	$
2	PAINT/DECORATING	1997		3	443	443	222						
3	PAINT/DECORATING	1998		3	675	1,349	1,349	674					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$ 3,757	$ 4,431	$ 4,210	$ 1,993	$	$	$	$	$

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? _____

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Ill Healthcare Assoc $11,104

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 5,340 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 106,215
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? n/a Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? no
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: RENAISSANCE CARE CENTER **#0040295** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,050	
	REPAIRS & MAINTENANCE		0	
				6,050
3	**HOUSEKEEPING**			
	FURNISHING SUPPLIES			
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		566	
			0	566
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		15,587	
	ELECTRICITY		70,202	
	WATER		18,397	
	CABLE TV - LOBBY		264	
			0	104,450
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,585	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,024	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,100	
	FIRE SERVICE		217	
			0	
			0	19,926
7	**OTHER**			
	SCAVENGER		7,187	
	SECURITY SERVICE		0	7,187
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	67,587	
	LABORATORY & XRAY EXPENSE		3,180	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,621	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	11,813	
			0	84,201
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	1,604	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,604
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	165	
	ACTIVITY PROGRAM EXP		1,953	2,118
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	5,490	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	5,490
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID#: RENAISSANCE CARE CENTER **#0040295** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	17,000	17,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,678	
	ADMINISTRATIVE CONSULTANTS	XIX C	27,563	
	PROFESSIONAL FEES	XIX C	30,571	
			0	63,812
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	12,433	
	EMPLOYEE WANT ADS	XIX F	18,047	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	11,880	
	LICENSES & PERMITS	XIX F	2,040	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	44,400
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		9,157	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		132,960	
	PENALTIES / OVERDRAFT CHARGES	VI 18	6,868	
	POSTAGE		3,696	
	THEFT & DAMAGE LOSS		164	
	TELEPHONE		10,110	
	MESSENGER SERVICE		0	
				162,955

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	173,091	
	UNEMPLOYMENT COMPENSATION	XIX D	27,151	
	WORKERS COMPENSATION INSURANC	XIX D	58,286	
	HOSPITALIZATION INSURANCE	XIX D	72,261	
	EMPLOYEE BENEFITS - OTHER	XIX D	894	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	OTHER	XIX D	0	331,683
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,392	
	TRAVEL	XIX G	0	
			0	
			0	1,392
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,467	11,467
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		90,394	90,394
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 954,695